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Analysis of Political Law and Public Policy on the Issue of BPJS Health Losses in the JKN Program in 2024

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Abstrak

Tahun 2024, BPJS Kesehatan menjadi sorotan terkait dugaan kerugian Program JKN sebesar Rp20 triliun, akibat potensi kecurangan dan inkonsistensi pengelolaan dana. Persoalan ini menimbulkan pertanyaan mengenai efektivitas kebijakan publik dan politik hukum dalam pengelolaan BPJS Kesehatan serta pengawasan terhadap program yang berdampak pada pelayanan kesehatan masyarakat. Penelitian ini bertujuan untuk menganalisis pengaruh politik, hukum, dan kebijakan publik yang dilaksanakan tahun 2024 terhadap tata kelola keuangan BPJS Kesehatan, khususnya terkait kerugian pada program JKN, serta mencari solusi perbaikan pengelolaan keuangan dan menekan kerugian. Metode penelitian yang digunakan adalah yuridis normatif, dengan menggunakan pendekatan perundang-undangan dan pendekatan analitis. Hasil penelitian menunjukkan bahwa ketidakseimbangan antara penerimaan iuran dengan biaya klaim, serta kebijakan subsidi silang yang tidak efisien menjadi penyebab utama terjadinya kerugian. Solusi kebijakan yang disarankan antara lain penyesuaian tarif iuran, perbaikan subsidi silang, penguatan pengawasan klaim medis, dan pengelolaan berbasis data yang lebih akurat. Penelitian ini menunjukkan perlunya kebijakan yang lebih responsif, efisien, dan berbasis data untuk mengatasi kerugian BPJS Kesehatan, serta pentingnya pengelolaan yang transparan dan akuntabel agar program JKN dapat berjalan berkelanjutan dan memberikan akses kesehatan yang merata bagi seluruh masyarakat Indonesia.
Kata kunci: BPJS Kesehatan, Program JKN, Kebijakan Publik, Pengelolaan Dana

Abstract

In 2024, BPJS Health will be in the spotlight regarding the alleged loss of IDR 20 trillion in the JKN Program, due to potential fraud and inconsistencies in fund management. This issue raises questions about the effectiveness of public policy and legal politics in managing BPJS Health as well as supervision of programs that affect public health services. This study aims to analyze the influence of politics, law, and public policies implemented in 2024 on BPJS Health's financial governance, especially related to losses in the JKN program, as well as to find solutions to improve financial management and reduce losses. The research method used is normative juridical, using a legislative approach and an analytical approach. The results show that the imbalance between the receipt of contributions and claim costs, as well as inefficient cross-subsidy policies, are the main causes of losses. Suggested policy solutions include adjustment of contribution rates, improvement of cross-subsidies, strengthening supervision of medical claims, and management based on more accurate data. This study shows the need for more responsive, efficient, and data-based policies to overcome BPJS Health losses, as well as the importance of transparent and accountable management so that the JKN program can run sustainably and provide equal access to health for all Indonesian people.
Keywords: *BPJS Health, JKN Program, Public Policy, Fund Management*

INTRODUCTION

Indonesia, as an archipelagic country with a large population, faces significant challenges in ensuring access to affordable and quality health services for all people (Alayda et al., 2024). The geographical condition consisting of thousands of islands with a large area and diverse characteristics makes the provision of facilities and health workers become difficult to reach evenly. In addition, the economic gap between urban and rural areas also causes some people, especially the underprivileged, to experience difficulties in financing the ever-increasing medical costs. Efforts to advance the health sector are an integral component of the national development agenda, which has the main goal of achieving maximum public health levels (Ulfah & Nugroho, 2020).

Healthy conditions are a human right and a form of investment for every citizen, including the underprivileged (Astuti, 2020). Therefore, a system is needed that regulates its implementation so that citizens' right to live a healthy life can be fulfilled. Without adequate health insurance, many people are forced to delay or even not get the health care they need, which can lead to worsening health conditions and increase the risk of poverty due to high health expenditure. Therefore, national health insurance is an urgent need for Indonesia to ensure access to affordable health services, improve people's quality of life, equalize access to health services throughout the region, and support economic development and labor productivity. With comprehensive and effective health insurance, Indonesia can improve the overall welfare of the community and accelerate the achievement of sustainable national development goals. In order to realize equal access to health insurance, the government has organized the National Social Security System (SJSN) in accordance with Law Number 40 of 2004. One of SJSN's flagship programs is the National Health Insurance (JKN) organized by the Health Social Security Administration Agency (BPJS). JKN provides health protection for all Indonesian populations, including underprivileged people whose contributions are paid by the government (Sri Isriawaty, 2015).

The Health Social Security Administration Agency (BPJS) is an institution established with the aim of realizing social justice in the health sector through the implementation of the National Health Insurance Program (JKN). This program aims to provide health protection for all Indonesian people, in accordance with the mandate of the 1945 Constitution Article 28H and Article 34 which affirm the right of every citizen to get access to proper health services. Since its launch in 2014, JKN has become one of the largest social security programs in the world, with a range of participants that continues to increase every year (Daming, 2020).

The National Health Insurance Program (JKN) emphasizes the need for health services in first-level health facilities. First-level health facilities that collaborate with BPJS Health must provide comprehensive health services, including promotive, preventive, curative, rehabilitative, midwifery services, and medical emergency management, including supporting services such as simple laboratory

examinations and pharmaceutical services (Suprapto & Malik, 2019).

With the number of participants continuing to increase, BPJS Health faces various challenges in managing funds and improving service quality. In 2024, BPJS Health will be in the public spotlight due to alleged losses of IDR 20 trillion. This allegation triggered various speculations related to fund management and potential fraud in the implementation of the JKN program. Although it was later clarified that this loss did not come from the JKN Program but from other public service programs, this issue still raises public concerns regarding the management of BPJS Health funds. The allegations sparked a wide debate about the effectiveness of supervision, accountability, and transparency in the management of public funds by BPJS Health. The public questions the extent to which existing public policies and legal politics are able to provide protection for funds managed by BPJS Health, considering their direct impact on public access to health services.

One of the main highlights in this issue is the weakness of the internal and external supervision mechanism in BPJS Health. Internal supervision is often incapable of detecting potential fraud early, while external supervision, carried out by institutions such as the Financial Audit Agency (BPK) and the Financial Services Authority (OJK), is more likely to be reactive than preventive. In addition, the regulations governing BPJS Health, such as Law Number 24 of 2011, are considered not comprehensive enough to face the complexity of fund management on such a large scale.

In the context of legal politics, the government's response to this issue is important. Legal politics reflects how the state formulates policies based on the needs of the community and the challenges faced. The delay in responding to the issue of losses not only affects public trust in BPJS Health, but also affects the perception of the state's ability to protect the interests of the community. Therefore, an in-depth evaluation of existing legal policies is needed, as well as the formulation of strategic measures to strengthen supervision and accountability in the management of BPJS Health funds.

The formulation of the problem in this study is as follows: 1). How will the legal politics and public policies implemented in 2024 affect BPJS Health's financial governance, especially related to the issue of losses in the JKN program? 2). What are the policy solutions that can be implemented in the future to improve BPJS Health's financial management and reduce ongoing losses?

RESEARCH METHODS

The approach method used is normative juridical research. The normative juridical research method is a literature law research conducted by researching library materials or secondary data (Sedarmayanti & Hidayat, 2011). Normative juridical research is a process to find legal rules, legal principles, and legal doctrines to answer legal problems faced (Marzuki, 2019).

The instrumentation in this study consists of a literature review and analysis of legal documents (Soekanto & Mahmudji, 2003). The main tools used are primary legal materials, namely Law No. 17 of 2023 concerning Health and the

1945 Constitution, Minister of Health Regulation Number 16 of 2019 concerning fraud prevention in JKN, and Law No. 40 of 2004 concerning the National Social Security System, while secondary legal materials are legal doctrines, academic literature, and scientific articles. All of these documents are used to explore and analyze the legal issues that are being researched. This research procedure begins by identifying relevant regulations and legal documents, followed by the collection and analysis of these legal materials. The data that has been obtained is then analyzed through a qualitative analysis approach, namely by observing the data obtained and connecting each data obtained with the provisions and legal principles related to the problem being researched (Moleong, 2002).

The data collection technique carried out is to conduct a study Legal Research in the form of literature research (Resarch Library), namely by collecting and studying and analyzing the provisions of laws related to health law. In this study, the scope of this research will be conducted by drawing legal principles, which are carried out on written and unwritten positive laws (Soekanto, 1996).

RESULTS AND DISCUSSION

Politics, Law, and Public Policy in Their Influence on BPJS Health Financial Governance Related to the Issue of Losses in the JKN Program

Legal politics and public policy play a very important role in BPJS Health financial management, especially related to the issue of losses that continue to arise in the National Health Insurance (JKN) program. As an institution tasked with providing health insurance for all Indonesian people, BPJS Health relies on funds derived from participant contributions and fund allocations from the government. However, the imbalance between the contributions received and the cost of medical claims that continue to increase has become a major challenge, which creates a deficit or loss for BPJS Health.

BPJS Health is an institution that has a very vital role in providing health insurance to all Indonesian citizens through the National Health Insurance (JKN) program (Basuki et al., 2016). In 2024, BPJS Health faces major challenges with losses estimated to reach around Rp 20 trillion. This figure not only reflects the imbalance in the financial management of the National Health Insurance (JKN), but also highlights various structural and operational problems that have not been resolved so far. This situation has triggered widespread attention from the public, stakeholders, and the government, considering the large implications of this deficit on the sustainability of the JKN program, which is the foundation of health services for millions of Indonesians. The legal politics applied in the management of BPJS Health have a very significant impact on this problem, especially related to financing policies, fund allocation, and existing regulations.

One of the political and legal aspects that affect these losses is the policy related to the amount of participant contributions. BPJS Health relies heavily on contributions paid by participants to cover the ever-increasing cost of medical claims. However, policies that regulate the amount of contributions do not always reflect the actual projection of

health service costs. As a result, the contributions received by BPJS Health are often insufficient to cover the costs that must be paid to hospitals and other health facilities. On the other hand, government policies that regulate the amount of hospital rates and health service costs also affect the financial burden of BPJS. The inconsistency between the increase in health service rates and the amount of contributions received by BPJS resulted in tension in financial management and led to a considerable deficit (Kurniawan et al., 2022).

Legal politics also plays a role in the cross-subsidy policy between independent participants and Contribution Assistance Recipients (PBI) participants. Cross-subsidies are policies that transfer part of costs from one group to another, with the aim of creating equity or equality in access to a service or product. In the context of BPJS Health, cross-subsidy means financing between independent participants (who pay full contributions) and Contribution Assistance Recipients (PBI) participants financed by the state or government.

This cross-subsidy aims to help underprivileged participants, but in practice, this policy adds pressure to independent participants who pay higher. Although the purpose of cross-subsidies to create equal access to health services for all levels of society is very good, in terms of BPJS financial management, this policy creates an imbalance. Financing for PBI participants that continues to increase, on the one hand, must be financed by independent participants, which causes inequality in financing the JKN program (Mentari, 2024). Political and legal policies that cannot balance the burden between independent participants and PBI participants can worsen BPJS Health's financial condition.

On the other hand, the problem of inefficient fund management also contributes to BPJS Health's losses. Although the funds collected from contributions and subsidies from the government are quite large, the management of these funds is not always optimal. One of the challenges faced is uncertainty in planning and allocating funds for health services. Decisions taken by BPJS Health and the government are often not based on mature projections regarding long-term financing needs. In addition, inefficiencies in the administration of medical claims and the management of health facilities also worsened BPJS Health's finances.

In this case, public policies implemented in the context of BPJS Health management must be able to overcome the imbalance between available financing and the ever-increasing cost of health services. One of the important steps that needs to be taken is a regulatory update that can align the amount of contributions with the actual financing needs. This regulation must also include adjustments to hospital rates and health services that are balanced with people's purchasing power, so that BPJS Health can cover medical claims without having to face continuous losses. In addition, the cross-subsidy management policy also needs to be reformed to create a balance in financing between independent participants and PBI participants. A more efficient policy in distributing assistance to PBI participants, without burdening independent participants,

will be very helpful in maintaining the sustainability of the JKN program. Stricter supervision of BPJS fund management and transparency in the medical claims process are also very important so that existing policies can be implemented efficiently.

Overall, the legal politics that govern BPJS Health financing play a key role in determining the extent to which BPJS Health can survive and carry out its duties well. If the policies implemented are not able to overcome the existing financing imbalance, then the potential for greater losses will be a burden for BPJS and the government (Purwandari et al., 2023). Therefore, a policy that is more responsive, based on accurate data, and can adapt to existing conditions is needed so that BPJS Health can continue to provide equitable and quality health insurance to all Indonesian people.

BPJS Health faces major problems related to the financial deficit which is estimated to reach around Rp 20 trillion in 2024. This loss figure comes from the imbalance between the receipt of participant contributions and the cost of medical claims that continue to increase. In various reports that have appeared, as explained by (Kompas, 2024)and (BBC, 2024) The losses in question actually lead to a potential deficit caused by the increasingly swollen cost of health services, while the income from contributions is not able to cover these costs. Medical claims that are much larger than the prepared budget are one of the main factors of the financial deficit that occurs. Although BPJS Health has clarified that the Rp 20 trillion loss figure circulating in the media is not an official report, this issue shows a structural imbalance in the management of JKN funds.

The inappropriate projection between the increasing cost of health services and the contributions received is also a major problem. The cross-subsidy policy implemented by the government to help Contribution Assistance Recipients (PBI) participants also has an unintended impact on BPJS Health financial management (Republika, 2024). This cross-subsidy is designed to ease the burden on underprivileged participants, but in its implementation, this policy actually adds to the burden on independent participants. This shows that despite the government's intention to help PBI participants, this policy is not fully efficient and instead worsens the financial condition of BPJS Health.

The increase in medical treatment costs, drug prices, and hospital rates also affected BPJS's financial balance. The government needs to immediately formulate more responsive and adaptive policies to deal with this projected growing deficit, one of which is by adjusting the rate of participant contributions to the actual cost needs, as well as improving the management of cross-subsidies to make it more efficient. Without the right policy and regulatory adjustments, the potential for an increasing deficit can worsen BPJS Health's financial condition, which will ultimately have an impact on the sustainability of the JKN program itself.

The clarification issued by BPJS Health emphasized that even though there was a mistake in the interpretation of the circulating loss figures, the problem of the budget deficit remained a reality that had to be faced. This issue highlights the importance of more transparent and efficient management,

as well as the need to update JKN financing regulations that are more realistic, based on more accurate cost projections and taking into account external factors such as inflation and rising medical costs. In this case, the legal and political policies that regulate the JKN financing system must be more aligned with the needs and challenges faced by BPJS, so that the losses that occur can be minimized and the sustainability of the JKN program can be well maintained.

Without the right policies and more efficient fund management, the losses incurred by BPJS Health can become a huge financial burden for the government and the community. Therefore, strict supervision of fund management and transparency in the medical claims process is very important so that BPJS Health can overcome this problem. One of the steps that can be taken is to introduce more flexible and data-based policies, so that BPJS Health can be more adaptive to changes in health conditions and community needs. Efficient and transparent financial management of BPJS, as well as responsive policies, will be the key in overcoming the potential deficit and maintaining the sustainability of the JKN program in the future.

Policy solutions that can be applied in the future to improve BPJS Health's financial management and reduce ongoing losses

BPJS Health has experienced deficits several times and has only experienced a surplus in 2020 to 2022 due to the Covid pandemic which has caused a decrease in participants' access to Health Facilities due to the switch from Health services to Covid disease services. The deficit in question is the imbalance between the receipt of contributions obtained and the realization of health service costs or in other words there is a negative balance between contribution receipts and the realization of health service costs. What is meant by Fraud in the National Health Insurance is an act that is deliberately fraudulent in the form of fraud to get financing for claims that are larger than they should be so that there are parties who are harmed (Purwandari et al., 2023).

In overcoming fraud in the National Health Insurance program, the Ministry of Health has issued a regulation in the form of Minister of Health Regulation No. 16 of 2019 concerning the Prevention and Handling of Fraud (Deceit) and the imposition of administrative sanctions against fraud (Deceit) in the implementation of the National Health Insurance Program. Cheating (deceit) is an action that is carried out deliberately to obtain financial benefits from the Health Insurance program in the National Social Security System through fraudulent acts that are not in accordance with the provisions of laws and regulations., so there are 3 elements that must be met when defining Deceit namely actions that are carried out deliberately, actions to obtain financial benefits and fraudulent actions that are not in accordance with the provisions so as to harm other parties (Hartati, 2017).

The potential for large losses due to fraud in JKN prompted the government to issue Regulation of the Minister of Health (Permenkes) Number 16 of 2019 concerning prevention deceit in JKN (Fajarwati et al., 2024). From the results of the analysis of this regulation, it is

recommended that there are advocacy efforts to stakeholders that have the potential to support the achievement of the main objectives of the policy. Deceit in the health sector is often caused by gaps in the financing system, which encourages some health facilities to take action deceit as a coping strategy. Therefore, a more in-depth study and evaluation of the JKN payment system is needed.

To reduce the ongoing losses to BPJS Health and improve financial management in the JKN program in the future, several policy solutions need to be implemented comprehensively and strategically, taking into account BPJS Health's internal factors as well as external factors affecting the health system in Indonesia.

First, a more realistic adjustment of contribution rates based on an accurate analysis of health cost projections is essential to ensure the continuity of the JKN program. Participant contributions, both for independent participants and Contribution Assistance Recipients (PBI) participants, must be adjusted to the needs of increasing health costs (Setiyono, 2018). The government needs to conduct an in-depth study of health service costs, such as hospital costs, medicines, increasingly expensive medical technology, and other factors that affect the national health budget. Along with the increase in inflation and the development of health technology, medical costs are getting higher, while the contributions received by BPJS Health cannot always adequately cover these costs. Adjusting the appropriate contribution rates and based on realistic projections will provide BPJS Health with a revenue stream that is more in line with the burden of claims that must be paid to health facilities. This tariff adjustment also needs to be done in a fair way, not burdening participants who are already in the lower middle economic group, so that no one is disadvantaged. Through the right adjustment of contributions, BPJS Health can maintain the sustainability of the JKN program and ensure the quality of health services for all participants.

Second, the policy regarding cross-subsidies between independent participants and Contribution Assistance Recipients (PBI) participants needs to be improved to be more efficient and on target. This cross-subsidy does aim to help underprivileged participants to be able to access health services without burdening them financially, but in practice, this policy has the potential to increase the burden for independent participants who have to pay higher compared to their level of need. The government should evaluate this cross-subsidy policy to be more efficient, taking into account the available budget capacity and ensuring that the participants receiving the subsidy are appropriate to the needs and capabilities of the government to provide such assistance (Trisnantoro, 2019). Alternatively, the JKN financing system can be more focused on increasing the state budget to support PBI participants, and reducing dependence on independent participants to bear excessive cross-subsidies. In addition, the government can make improvements to PBI participant data to be more accurate and on target, so that the financing of the JKN program is more effective and in accordance with existing needs.

Third, strengthening the supervision system and transparency in BPJS Health financial management is very important to avoid fund leakage, budget abuse, and errors in the claim process (Arifin et al., 2024). In this case, information technology (IT) plays a huge role. The government can introduce stricter oversight policies through the use of digital-based systems to monitor and manage medical claims in a more transparent and accountable manner. By utilizing more advanced technology, BPJS Health can minimize fraud in submitting claims, speed up the claim verification process, and ensure that the funds spent to pay for medical claims are truly in accordance with the treatment provided. In addition, supervision involving third parties or independent institutions is also important to ensure the integrity of JKN fund management. The government and BPJS Health must work together to ensure that every process of fund management, from the collection of contributions to the payment of claims, is carried out with full transparency and in accordance with applicable regulations.

Fourth, increasing cooperation between BPJS Health and health facilities, both hospitals and other health service providers, to set rates that are more in line with the actual cost of health services is a crucial solution. BPJS Health needs to renegotiate with hospitals to determine more realistic rates, considering that previously agreed claim rates are often not proportional to the costs incurred by hospitals. The government needs to create policies that support a fair agreement between BPJS Health and health facilities, taking into account cost efficiency factors and the quality of services that must be maintained. This can include providing incentives to hospitals that seek to reduce costs and improve service quality, as well as enforcing a policy of regular evaluation of hospital rates to adjust to economic conditions and applicable costs in the field. The government can also introduce policies to improve the efficiency of services in hospitals by encouraging hospitals to implement more efficient medical technology and better management systems, which in turn can lower operational costs and improve the quality of services.

Fifth, to reduce the losses that occur, it is important for BPJS Health to make efforts to prevent the increase in the number of uncontrolled claims. BPJS Health needs to be more proactive in preventing waste of health services through various promotive and preventive programs that prioritize disease prevention, such as by introducing public health programs that are more integrated and based on long-term health needs (Arifin et al., 2024). The government can also launch educational campaigns to raise awareness of the importance of prevention, early treatment, and management of chronic diseases, which in turn will reduce the high number of medical claims and reduce the burden of medical costs. In addition, BPJS Health can facilitate the use of primary health facilities, such as clinics and health centers, so that people do not need to directly access hospitals for minor treatment, so that they can reduce the swelling of claims.

Finally, a comprehensive update policy to the JKN financing system must

be based on accurate data and projections of long-term financing needs. The government needs to formulate financing policies based on realistic calculations by taking into account external factors that affect health financing, such as inflation, rising medical costs, and the needs of a growing population (Uly, 2019). For this reason, more in-depth research and analysis is needed on the management of JKN funds, involving related parties, both from the health, economic, and public policy sectors. The government must also have a strong commitment to maintain the sustainability of this program by ensuring that the funds used are actually used in accordance with the top priority, which is to provide fair and equitable access to health for all Indonesians.

By implementing these policies in an integrated manner and based on valid data, it is hoped that BPJS Health can overcome the losses that occur, maintain the sustainability of the JKN program, and ensure fairer and more equitable health services for all Indonesian people. This will strengthen the national health insurance system and ensure access to better, more efficient, and more affordable health services for all levels of society.

CONCLUSION

Legal politics and public policy have a significant influence on BPJS Kesehatan's financial governance, especially in the face of continuing losses in the National Health Insurance (JKN) program. The imbalance between contribution revenue and medical claim costs is the main cause of losses, which is exacerbated by the ineffective implementation of the cross-subsidy policy between independent participants and beneficiaries. In addition, health service cost projections that are not based on realistic calculations, medical tariff increases that are not proportional to contribution revenues, and inefficient fund management contribute to the financial deficit experienced by BPJS Kesehatan. On the other hand, potential fraud in medical claims and budget leakage are also serious challenges that require stricter supervision. Less transparent fund management, coupled with a weak technology-based monitoring system, worsens BPJS's financial condition.

Policy solutions that can be implemented in the future to improve BPJS Kesehatan's financial management and reduce continuing losses include adjusting contribution rates based on accurate cost projections, improving cross-subsidy mechanisms to be more efficient and targeted, and strengthening financial supervision by utilizing digital technology to prevent fraud. In addition, there is a need to increase cooperation with health facilities to set realistic tariffs and encourage service efficiency. Promotive and preventive programs should also be expanded to reduce the number of uncontrolled claims. With valid data-based planning and long-term needs projections, BPJS Kesehatan can maintain the sustainability of the JKN program, reduce losses, and ensure fair, efficient, and equitable access to health services for the entire community.

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